STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for an Initial Certification and State Licensure Survey. Survey dates: August 8, 9, 10, and 11, 2011 Facility number: 000255 Provider number: 155364 AIM number: 100273280 Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN Carol Miller, RN Census bed type: SNF/NF: 124 Total : 124 Census Payor type: Medicare: 2 Medicaid: 121 Other: 1 Total: 124 Sample: 24 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/17/11	F0000	This plan of correction will serve as the written allegation of compliance. Preparation and/or execution of the plan of correction does not constitute admission or agreement by Byron Health Center or the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared as a provision of federal and state regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0221 SS=D	Cathy Emswiller RN The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review, and interviews, the facility failed to ensure less restrictive alternatives were attempted prior to applying a physical restraint for 1 of 4 residents reviewed for restraints in a sample of 24. (Resident #81) In addition, the facility failed to ensure restraints were released as care planned for 2 of 4 residents reviewed for restraints in a sample of 24. (Residents #32 and #112) Findings include: 1. During the initial tour of the facility, conducted on 08/08/11 between 8:45 A.M. - 9:15 A.M., with the Director of Nursing, Resident #81 was observed seated in a reclining geri chair with a lap tray in the day lounge. The clinical record for Resident #81 was reviewed on 08/09/11 at 1:15 P.M. A physician's order, dated 08/03/11, indicated the following: "up in geri chair when acting compulsively and inappropriately, danger to self/others related to schizophrenia check every hour	F0221	1. Resident #81 was assessed for any possible complication related to failure to document alternatives tried before an "as needed" restraint was applied. None were found. Resident #32 and #112 were assessed for any possible complications related to failure to check every hour and release every two hours. No negative outcomes were assessed.2. All residents utilizing restraints were assessed for appropriate usage, timely checks, and release of restraints. Any deficiencies found were addressed immediately.3. Nursing staff will be educated on the requirement for charting of alternatives tried before the use of "as needed" physical restraints and the requirement for every one hour checks, and every two hour release of restraints. The restraint policy has been revised to reflect the need to chart alternatives tried before the application of an "as needed" restraint. (See attachment #221-A). All prn or "as needed" restraint orders will be discontinued and doctor will be called and an order obtained as / when needed.4. All residents utilizing restraints will be	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and release every 2 hours." (sic) The resident also had a physician's order for a soft waist restraint when up. Resident #81 was observed on 08/09/11 at 1:15 P.M. propelling her wheelchair down the hallway to her room. The resident was restrained in the wheelchair with a soft waist restraint. Nursing notes, dated 08/08/11, did not reveal any documentation of behavior issues requiring the use of the more restrictive geri chair with lap tray restraint. Interview with Director of Nursing, on 08/10/11 at 2:00 P.M. indicated a restraint record form had been completed which did indicate the use of the geri chair and the every two hour release and every hour check, but there was no documentation of the specific behaviors and other alternatives attempted prior to the use of the more restrictive restraint. A behavior incident report, dated 08/08/11 at 2:00 P.M. indicated the resident was wandering in her wheelchair in and out of other residents rooms, taking water pitchers and pouring water and drinking water and was not redirectable. The form indicated there were various alternatives attempted including validating her feelings, distractions, verbal redirection,		monitored daily by nursing management over all three shifts for a period of 30 days. Immediate action will occur if non-compliance with the restraint policy is found. If at the end of the 30 day period compliance is evident, monitoring will continue on a weekly basis for three months. At that time if compliance continues, monitoring will continue on a monthly basis for no less that 9 months. The Director of Nursing will review all monitoring reports monthly, and follow up on any education or disciplinary action required. The Director of Nursing will forward a monthly report to the QA Committee. After 9 months, the QA Committee will decide under what conditions monitoring will continue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and removing the resident from the environment. However, interview with the nurse completing the form, on 08/10/11 at 2:00 P.M. indicated the behavior form was completed for behavior issues which had occurred on 08/08/11 after the resident had been put back into her wheelchair. She indicated the form was not completed in connection with the use of the geri chair observed in the morning on 08/08/11. 2. Resident #32's record was reviewed 8/8/2011 at 10:50 A.M. Resident #32's diagnoses included but were not limited to, mental retardation, depression, and arthritis. A current physician's order dated 8/2011 indicated a soft waist restraint to be used when up in chair was to be checked every hour and released every 2 hours. During a continuous observation on 8/8/2011 between 12:23 P.M. and 3:22 P.M. Resident #32 was up in her wheel chair with a soft waist restraint on in the hall, in the lobby, in the resident lounge, and at bingo without the restraint being checked or released during that time. Her restraint was released and she was toileted at 3:22 P.M. when she asked CNA#1 to take her to the restroom. During a continuous observation on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/10/2011 between 8:02 A.M. and 11:20 A.M. Resident #32 was up in her wheel chair with a soft waist restraint on in the dining area, went to therapy, to the lobby, then back to her room without the restraint being checked or released during that time. Her restraint was released and she was toileted at 11:20 A.M. when she asked CNA #2 to take her to the bathroom. In an interview on 8/10/2011 at 11:30 A.M. LPN #3 indicated Resident #32's waist restraint should have been checked and released as ordered by the physician. 3. Resident #112's clinical record was reviewed on 8/8/11 at 1:30 P.M.. The record indicated the resident had physician's orders dated 7/28/11 for a soft waist restraint when up in wheelchair related to confusion related to safety awareness related to dementia. To check every hour and release every 2 hours. On 8/9/11 a continuous observation of the resident from 1:00 P.M. to 3:30 P.M. indicated the resident was not released from his soft waist restraint every 2 hours as per physician's orders. Observations at various times included: 1:00 P.M.: The resident returned to the unit from therapy and was taken directly into the dining room. The resident was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wearing the soft waist restraint. 1:10 P.M.: The resident was eating in the dining room and had the soft waist restraint on. 1:30 P.M.: The resident was slowly propelling himself down the hallway and had on the soft waist restraint. When asked where he was going the resident indicated he wanted to go to bed. 2:05 P.M.: The resident went into his bedroom and had on the soft waist restraint. 2:20 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. 2:50 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. 3:00 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. Two staff members (CNA's #6 and #7) came into the resident's room and made the resident's bed. 3:05 P.M.: CNA #7 gave resident photos. CNA #7 interviewed and indicated the resident liked to look at photos of his family. 3:20 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. 3:30 P.M.:The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The continuous observation ended after the 3:30 P.M. observation. The resident was not observed to have been released from his soft waist restraint during the two and one half hour continuous observation. Review of the facility policy for "Restraints-Physical" indicated: #6 "Any resident with a restraint must be released every two hours or more frequently if necessary;" #7 "The resident, when released, must be toileted, ambulated if able, changed, and repositioned as the resident's condition allows"; 8. "All residents with a restraint must have a Restraint Record. The record shall include the type of restraint and the release time." 3.1-26(h)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure a resident who needed psychiatric care received the care timely for 1 of 14 residents reviewed for behaviors in a sample of 24. (Resident #59)	F0250	1. The facility did attempt to get ordered ECT care for this resident, but unfortunately had difficulty in response/coordinating psychiatric inpatient hospitalization with the psychiatristResident was admitted to psychiatric unit hospital on 8/11/11 and ECT	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: 1. During the initial tour of the facility, conducted on 08/08/11 between 8:45 A.M. - 9:15 A.M., the Director of Nursing indicated Resident #59 was very hard to redirect, had behavior issues, needed ECT (electric convulsive treatments) treatments, and received psychotropic medication. Resident #59 was observed on 08/08/11 at 9:15 A.M., propelling herself in her wheelchair down to the exit door to the unit. The resident was redirected several times to go down to the lounge area on the opposite end of the secured unit. During a confidential interview, conducted on 08/09/11 at 9:00 A.M., a resident who resides on the secured unit with Resident #59 indicated the resident frequently entered her room and removed her personal items, yelled at her, cursed at her, and attempted to hit her at times. The resident, Resident #300, indicated she was afraid of Resident #59. During observation of resident activity on 08/10/11 at 1:40 P.M., Resident #301 indicated she was afraid of Resident #59 because she had threatened to hit her and also took her personal items. She indicated Resident #59 "just gets meaner		treatments were started there. She returned to facility on 8/23/11 and continues ECT treatment, 3 times a week per psychiatrist's order. She has a follow-up appointment with psychiatrist on 9/29/11.All behavior plans/care plans have been reviewed and updated for ECT treatment and for resident's current behaviors. She will be closely monitored and observed for resident to resident interaction and other behavior challenges that she experiences.No residents were found to be in need of ECT services from the aforementioned psychiatrist.2. Any resident requiring ECT services in the facility could be affected by this practice.3. If difficulties occur with obtaining psychiatric services, the facility will involve its Medical Director to expedite services.4. The Director of Nursing will forward a monthly report concerning any problems obtaining ECT care for any resident to the QA Committee on a monthly and ongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and meaner." The clinical record for Resident #59 was reviewed on 08/10/11 at 2:00 P.M. Resident #59 was admitted to the facility on 05/28/09 with diagnosis, including but not limited to schizophrenia, organic brain syndrome, history of water intoxication, paranoia, and dementia. Nursing notes, dated 07/17/11 at 9:00 P.M. indicated the resident became irate when asked what she was doing. Nursing notes, dated 07/18/11, at 8:20 P.M. indicated she was not able to be redirected from throwing her clean clothes in the linen barrel. On 07/19/11 at 8:00 A.M., the resident was angry and yelling because staff would only allow her to take two extra cups off of the medicine cart. On 07/20/11 at 2:00 P.M., the resident was noted to have an increase in agitation, was redirected many times from entering other residents rooms, and was yelling throughout the day and the night. She was also vacillating from yelling to talking in a whiney "kids" voice. On 07/22/11 at 9:00 P.M., the resident was noted to have an increase in agitation, yelling and screaming, had thrown water all over another resident's bed, and was not easily redirected. On 07/23/11 at 4:00 A.M., the resident was noted to tear up toilet paper rolls and attempted to blame it			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on another resident who was sleeping. On 07/23/11 at 6:00 P.M., the resident was noted to go into another resident's room and yank a necklace off of another resident's neck. On 07/25/11 at 9:30 A.M., the resident's psychiatrist was notified of the resident's increasing behavior issues. On 07/29/11 the resident was seen by the psychiatrist who ordered "needs to start back on ECT's." Review of nursing notes, from 07/29/11 - 08/06/11, indicated there was no documentation regarding the resident restarting ECT treatments. Nursing notes, dated 08/07/11 at 1:00 P.M. indicated the psychiatrists office was notified regarding the need for additional orders required before the resident could receive ECT treatments. The information was also faxed to the psychiatrist's office. There was no documented response from the psychiatrist. A physician's order was received on 08/08/11 at 2:15 P.M. indicated the resident was to go to the emergency room to be admitted to the inpatient psychiatric unit. Interview with the Director of Nursing, on 08/09/11 at 2:45 P.M. indicated the resident was not sent to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	emergency room because the psychiatrist had not notified the emergency room and set up a direct admission to the inpatient psychiatric facility. She indicated without the coordination of physician orders from the resident's psychiatrist, the resident would have just sat in the emergency room for a few hours, probably had an increase in agitation and behaviors, and then would have been returned to the facility a few hours later. Nursing notes, dated 08/09/11, completed as a late entry, indicated the "assessment" team was not available at the emergency room. The psychiatrist was notified but did not respond to the facility's request or call the emergency room to coordinate the resident's care. Interview with the Director of Nursing, unit manager, LPN #5, and unit clerk, employee #6, on 08/11/11 at 2:30 P.M. indicated 08/01/11, the unit clerk, employee #6 had called the acute care facility to see if Resident #59 had been set up for ECT treatments. She was advised by the acute care center to call another psychiatrist's nurse to check on the status. Employee #6 then spoke with the psychiatrist's nurse on 08/01/11 who informed her the resident's psychiatrist needed to coordinate the preliminary tests and insurance needs before the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could receive ECT treatments. Interview with LPN #5 indicated Resident #59's psychiatrist was very hard to get ahold of and did not call the facility back when notified of issues. She indicated she did not notify the medical director of the issue because she had been calling the psychiatrist's office herself. The Director of Nursing indicated the facility's medical director was out of the country and his physician's assistant was covering for him. She indicated the psychiatrist would probably not respond to the physician's assistant either. 3.1-34(a)			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, and interview the facility failed to maintain paint in resident restrooms in 10 resident rooms located on 5 of 6 units. This had the potential to affect 83 of 124 residents residing in the facility. Findings include: A resident census provided by the Administrator on 8/8/2011 at 8:45 A.M. indicated there were 24 residents in section 10, 24 residents in section 11, 6	F0253	1. No residents were found to be negatively affected by this deficient practice.2. No other residents were nor will be found to be affected by this deficient practice. Citations were in toilet areas that are used by only a limited number of residents. While the citation stated that up to 83 residents could have been affected by this citation, in fact only 14 residents had the potential to be afected by this citation as the areas cited are not open areas and are not used by all residents.3. Bathrooms cited	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents in section 12, 5 residents in section 13, and 24 residents in section 14. During environmental tour on 8/9/2011 at 10:00 A.M. flaking paint was noted around the commode between rooms 11-10 and 11-9. The paint was flaking in a semicircular area behind the commode approximately 4 inches in width and two cinder blocks long. During environmental tour on 8/9/2011 at 10:15 A.M. flaking paint was noted around the commode between rooms 12-7 and 12-6. The paint was flaking in small circular areas behind the commode 4 areas approximately baseball sized. During environmental tour on 8/9/2011 at 10:20 A.M. flaking paint was noted around the commode between rooms 13-8 and 13-9. The paint was flaking in a semicircular area behind the commode approximately 6 inches in width and two cinder blocks long. During environmental tour on 8/9/2011 at 10:35 A.M. flaking paint was noted around the commode between rooms 10-12 and 10-11. The paint was flaking in 6 small areas behind the commode approximately ping- pong ball sized. During environmental tour on 8/9/2011 at		will be recaulked, scraped and repainted. Bathrooms will be inspected as a part of weekly survey rounds, will be recorded with any findings and will be reported to facility wide QA committee on a quarterly basis.4. Deficient areas will be surveyed on a weekly basis by the survey team assigned to that area, findings will be recorded and reported to the facility QA Committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:38 A.M. flaking paint was noted around the commode between rooms 14-6 and 14-7. The paint was flaking in small areas behind the commode approximately 3 inches in width and two cinder blocks long. In an interview with the Director of Maintenance on 8/9/2011 at 11:00 A.M., he indicated paint should be intact around the commodes. He further indicated there was no set painting schedule and the painting was done on a by unit and subject (ceiling, rooms, halls, etc) basis. 3.1-19(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to maintain a care plan addressing suicidal ideation during medication adjustment for 1 of 1 residents reviewed for care plans addressing suicidal ideation in a sample of 24. (Resident #36) Findings include: Resident #36's record was reviewed 8/10/2011 at 2:00 P.M. Resident #36's diagnoses included but were not limited to schizophrenia, depression, and seizure disorder. A nurse's note dated 6/8/2011 at 1:30 P.M.	F0279	1. The history of suicidal ideation care plan was restored to the resident's care plan on 8/12/2011. A new care plan was written for this resident for preventative measures about harming self. Resident was seen by the facility psychologist on 8/23/2011, and resident denied any current suicidal ideation. He will see her on a routine basis, with the next appointment taking place the end of September.The resident was assessed for her annual MDS from 8/9/2011 to 8/15/2011 and was hot racked during this time period for suicidal ideations. There were no incidents of resident having suicidal ideations during this time period. Her MDS interview on 8/12/2011 indicated that over the	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident #36 had suicidal ideation's. She was immediately placed on 15 minute checks, placed on the secured unit and the physician was notified. A care plan addressing suicidal ideation's was initiated. Social notes on 6/8/2011, indicated Resident #36's suicidal thoughts began when she became overwhelmed several days prior to that. The notes further indicated on 6/9, and 6/14 Resident #36 was feeling better and was having no suicidal ideation. On 6/16/2011, Resident #36's attending physician visited. He indicated in his progress note Resident #36 was stable, 15 minute checks could be discontinued, and she could be moved to her room on the open unit. The care plan addressing suicidal ideation was discontinued. On 6/21/2011 a psychologist reviewed Resident #36, and indicated in his progress notes she was stable and requested a medication review. The psychologist visited again on 7/12/2011 with no further recommendations. On 7/21/2011 a psychiatrist reviewed Resident #36. He discontinued Celexa (an antidepressant) and ordered Zoloft (a different antidepressant) 50 milligrams to		last two weks, she had not had suicidal thoughts or thoughts of harming herself.2. The MDS Social Worker will check the care plans of all residents who have moved off or on secure units related to suicidal ideations for the last 90 days to insure that no care plans have been inadvertently discontinued.3. The facility has a secure unit policy already in effect and this policy will be followed for all discharges from secure unit (See Attachement 279-A). This policy states that any resident transferred back to an open unit will have a trial period that is set up by the resident's Quality of Life Coordinator after approval for trial has been given by the resident's physician/psychiatrist/psychologis t and the Executve Director. During this trial period, the resident will be hot racked to monitor for adverse adjustment problems. In addition, the Quality of Life Coordinator will monitor the trial and write progress notes in the resident's chart. All care plans related to secure unit placement and suicidal ideations will be updated to rellect these changes and remain in effect for 90 days.4. The Behavior Management Committee oversees all admissions and discharges to and from the secure units. This committee will report monthly to the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be given daily for two weeks, then to increase the dose to 100 milligrams per day. A care plan addressing potential for suicidal thoughts related to the medication change was not initiated. In an interview with the Social Worker on 8/11/2011 at 2:00 P.M., she indicated the care plan addressing suicidal ideation had been inadvertently discontinued and that one should have been available to the staff. 3.1-35(a)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to implement interventions as ordered by the physician for 1 of 3 residents reviewed for oxygen use (Resident #32), 1 of 2 residents reviewed for personal alarm use (Resident #32), 2 of 3 residents reviewed for restraint release (Resident #32 and Resident #112) and 1 of 5 residents reviewed for family notification after a fall (Resident #95) in a sample of 24. Findings include:	F0282	1. Resident #32 was assessed for any ill effects related to improper oxygen use, failure to use a tabs alarm, and failure to release a soft waist restraint. No ill effects were assessed. A tabs alarm was added to resident #32's chair on 8/10/11. The soft waist restraint was discontiued on 8/10/11, with no ill effects noted. Resient #32 was found to be changing her oxygen flow rate herself. A care plan was added to her clinical record, and monitoring of her flow rate was added to her treatment administration record. Resident #32 is currently being assessed for the continued need	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1.a. Resident #32's record was reviewed 8/8/2011 at 10:50 A.M. Resident #32's diagnoses included but were not limited to mental retardation, depression, and arthritis. A current physician's order dated 8/2011 indicated Resident #32 was have oxygen administered at 4 liters per minute per nasal canula. In an observation on 8/8/2011 at 12:23 P.M. Resident #32 was in her wheel chair in the dining room. Her oxygen was set on 3 liters per minute. When the oxygen walker was checked, the walker was noted to be empty. The observation continued until 3:20 P.M. The oxygen was never refilled. Resident #32's skin was pink and breathing was full and regular. She exhibited no signs of distress. Oxygen saturations documented on 8/8/2011 on the 7-3 and 3-11 shifts were 95% and 94% respectively. In an observation on 8/10/2011 at 8:02 A.M., it was noted resident #32's oxygen was set on 3 liters per minute. The oxygen walker was full when checked. The observation continued until 11:20 A.M. The oxygen flow had not been changed during the observation. Resident #32's skin was pink and her breathing was full and regular. Resident #32 exhibited no		for oxygen.Resident #112 was assessed for any ill effects from not being checked every hour, or released every two hours from a soft waist restraint with no adverse outcomes being found.The family of resident #95 was contacted on 8/11/11 and informed of the falls of 5/27/11 and 8/1/11.2. Incident reports for the month of July were reviewed and families notified where necessary. All residents utilizing restraints were assessed for appropriate usage, timely checks, and release of restraints. All residents using oxygen were checked to confirm appropriate usage.3. The Incident Report has been revised to clearly delineate the need to notify both the POA and the family. (See Attachment F282-A). All nursing staff will be inserviced on proper notification of family members for all incidents, the proper application and monitoring of restraints and oxygen.4. All residents utilizing restraints and oxygen will be monitored daily by nursing management over all three shifts for a period of 30 days. Immediate action will occur if non-compliance with the restraint policy or oxygen usage is found. If compliasnce is evident at the end of 30 days, monitoring will continue on a weekly basis for 3 months. At that time if compliance continues, monitoring will continue on a monthky basis for 9 months. The Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	signs of distress. Oxygen saturations documented on the 7-3 shift for 8/10/2011 was 94%. In an interview on 8/10/2011 at 11:30 A.M. LPN #3 indicated Oxygen should be as ordered by the physician. 1.b. A current physician's order dated 8/2011 indicated a tab alarm was to be used on Resident #32's wheel chair whenever she was in the chair. In an observation on 8/8/2011 at 12:23 P.M. Resident #32 was observed in the dining room without the alarm on her chair. In an observation on 8/8/2011 at 3:22 P.M. Resident #32 was observed in her room without the alarm on her chair. In an observation on 8/10/2011 at 10:00 A.M. Resident #32 was observed in the therapy area without the alarm on her chair. In an interview on 8/10/2011 at 11:30 A.M. LPN #3 indicated the tab alarm should not be on Resident #32's chair because she was on a soft waist restraint and therefore the staff was not utilizing the alarm.		Nursing will review all monitoring reports monthky, and follow up on any education or disciplinary action required. The Director of Nursing will forward a monthly report to the QA Committee. After 9 months, the QA Committee will decide if monitoring should continue. All Incident Reports will be monitored by the Nurse Manager on second shift for completeness and appropriate notification of family on an ongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 8/10/2011 at 1:30 P.M. the Director of Clinical Services indicated the alarm should have been on Resident #32's wheelchair as ordered. 1. c. A current physician's order dated 8/2011 indicated a soft waist restraint to be used when up in chair was to be checked every hour and released every 2 hours During a continuous observation on 8/8/2011 between 12:23 P.M. and 3:22 P.M. Resident #32 was up in her wheel chair with a soft waist restraint on in the hall, in the lobby, in the resident lounge, and at bingo without the restraint being checked or released during that time. Her restraint was released and she was toileted at 3:22 P.M. when she asked CNA#1 to take her to the restroom. During a continuous observation on 8/10/2011 between 8:02 A.M. and 11:20 A.M. Resident #32 was up in her wheel chair with a soft waist restraint on in the dining area, went to therapy, to the lobby, then back to her room without the restraint being checked or released during that time. Her restraint was released and she was toileted at 11:20 A.M. when she asked CNA #2 to take her to the bathroom.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 8/10/2011 at 11:30 A.M. LPN #3 indicated Resident #32's waist restraint should have been checked and released as ordered by the physician. 2. Resident #112's clinical record was reviewed on 8/8/11 at 1:30 P.M.. The record indicated the resident had physician's orders dated 7/28/11 for a soft waist restraint when up in wheelchair related to confusion related to safety awareness related to dementia. To check every hour and release every 2 hours. On 8/9/11 a continuous observation of the resident from 1:00 P.M. to 3:30 P.M. indicated the resident was not released from his soft waist restraint every 2 hours as per physician's orders. Observations at various times included: 1:00 P.M.: The resident returned to the unit from therapy and was taken directly into the dining room. The resident was wearing the soft waist restraint. 1:10 P.M.: The resident was eating in the dining room and had the soft waist restraint on. 1:30 P.M.: The resident was slowly propelling himself down the hallway and had on the soft waist restraint. When asked where he was going the resident indicated he wanted to go to bed. 2:05 P.M.: The resident went into his bedroom and had on the soft waist restraint.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2:20 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. 2:50 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. 3:00 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. Two staff members (CNA's #6 and #7) came into the resident's room and made the resident's bed. 3:05 P.M.: CNA #7 gave resident photos. CNA #7 interviewed and indicated the resident liked to look at photos of his family. 3:20 P.M.: The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. 3:30 P.M.:The resident was sitting in his bedroom in his wheelchair and had on the soft waist restraint. The continuous observation ended after the 3:30 P.M. observation. The resident was not observed to have been released from his soft waist restraint during the two and one half hour continuous observation. 3. Resident #95's clinical record was reviewed on 8/9/11 at 1:00 P.M.. The record indicated the resident had an overall plan of care for risk for falls due to antipsychotic medication use. One of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions for the plan of care was to notify MD, Physical Therapy and family of all falls. Review of the resident's nurse's notes from 5/27/11 indicated the resident had a fall at 4:00 A.M.. The nurse's notes did not indicate notification of family. The DN (Director of Nursing) provided a document of the quality assurance report of incidents for the fall on 5/27/11. The report did not indicate notification of family. Review of the resident's nurse's notes from 8/1/11 indicated the resident had a fall at 4:00 A.M.. The nurse's notes did not indicate notification of family. The DN (Director of Nursing) provided a document of the quality assurance report of incidents for the fall on 8/1/11. The report did not indicate notification of family. An interview with the Social Service Director (SSD) on 8/11/11 at 2:40 P.M. indicated the resident has two sisters who have very little involvement with the resident. The SSD indicated neither of the sisters were notified of the falls on 5/27/11 or 8/1/11. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review the facility failed to complete 15 minute checks as a nursing measure for 1 of 1 residents reviewed on a locked unit with suicidal ideation in a sample of 24. (Resident #36) Findings include: Resident #36's record was reviewed 8/10/2011 at 2:00 P.M. Resident #36's diagnoses included but were not limited to schizophrenia, depression, and seizure disorder. A nurse's note dated 6/8/2011 at 1:30 P.M. indicated Resident #36 had suicidal ideation's. She was immediately placed on 15 minute checks, placed on the secured unit and the physician was notified. A review of 15 minute check documentation indicated there were no checks completed 6/10/2011 between 7 A.M. and 2:30 P.M.;and 6/12 between 7:00 A.M. and 2:30 P.M. A review of nurse's notes dated 6/10/2011	F0309	1. Resident #36 was assessed for any ill effects related to this deficient practice. None were found. Resident #36 was again assessed by a psychologist on 8/23/11, and denied any suicidal ideations or plans. The psychologist will follow her on a routine basis with the next appointment at the end of September. Resident #36 was assessed for her annual MDS from 8/9/11 through 8/15/11. During this time she was hot racked for suicidal ideations. There were no incidents of the resident having suicidal ideations during this time frame. Her MDS interview on 8/12/11 indicated that over the last two weeks she had not had suicidal thoughts or thoughts of harming herself.2. Any resident threatening suicide with a valid plan was assessed as being at risk. At present there are no residents assessed as having suicidal ideations with a valid plan.3. The third shift nurse manager or designee will be responsible for initiating the sheets necessary to document every fifteen minute checks when the need arises. These sheets will contain, at a minimum, the	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 6/12/2011 did not indicate 15 minute checks were being completed. In an interview with the Director of Clinical Services, she indicated the fifteen minute checks should have been completed. 3.1-37(a)		resident's name, the shift, the dte, and an area to validate the every fifteen minute checks. When these sheets are deemed necessary, they will continue until the physician orders them to cease.4. The third shift Nurse Manager will forward a monthly report of all residents requiring every fifteen minute checks to the QA Committee on an ongoing basis. This report will contain verification by the third shift Nurse Manager that these checks occurred, and sheets were available for documentation purposes if needed. The QA Committee will assess for the continued need for the report after nine months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review the facility failed to maintain clean fans in the clean linen area of the small laundry. The facility also failed to maintain ceiling paint in a	F0441	1. No residents were found to be affected by this deficient practice. Infection rates were checked and no increases were noted and no infections that could have been attributed to this infraction were	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	manner preventing the paint from peeling in the clean linen area of the small laundry. This had the potential to affect all residents in the building. Findings include: During the environmental tour on 8/9/2011 at 9:35 A.M. two fans with gray feathery particles blowing in the breeze from the fan blades were noted to be blowing across clean linen in the small laundry area. Additionally, flaking white paint was noted on the ceiling over the clean linen with the potential to fall on the clean linen and contaminate it. In an interview with the Housekeeping Director on 8/9/2011 at 11:10 A.M. he indicated the fans were to be cleaned on a weekly basis. A copy of the laundry fan cleaning schedule provided by the Housekeeping Director on 8/10/2011 at 9:40 A.M. indicated the fans were to be cleaned weekly. In an interview with the Director of Maintenance on 8/9/2011 at 11:00 A.M. he indicated although there was no schedule for painting the laundry area, the paint should have been kept intact in the clean linen area of the laundry.		identified.2. No other residents were found to be affected by this deficient practice.3. Fans that were cited have been removed and will no longer be a source of collected dust. Ceilings will be scraped and repainted.4. The area (ceilings) will be observed for flaking paint during survey rounds conducted on a weekly basis by survey team members assigned to this area. Findings will be recorded and reported to the facility QA committee on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-18(j)			
F0499 SS=D	The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on interview and record review the facility failed to ensure valid CNA certification for one CNA. This had the potential to affect all 30 residents on one unit (Section 11 and 12) of the facility. Findings include: A resident census provided by the Administrator on 8/8/2011 at 8:45 A.M. indicated there were 26 residents residing on section 11 and 6 residents residing on section 12. During review of licenses it was noted CNA #4's certification had expired on 5/22/2011. CNA #4 had worked 40 shifts since her expiration, the last shift being 8/8/2011 on second shift. Staffing reports indicated she had worked sections 11 and 12 exclusively between 5/22 and 8/8/2011.	F0499	1. Immediately renewed the CNA Certification.2. Director of Human Resources and Employment Specialist conducted an audit of 100% of Nursing/CNA, etc. staff files to ensure all licenses were current and copies in the Licensing Manual.3. When a new nursing employee begins employment with Byron Health Center, 2 copies of the license/certification will be made. 1 copy will be placed in the Licensing Manual and 1 copy will be placed in the employee file. Employment Specialist was made aware of this practice.4. Licensing Manual will be reviewed on a monthly basis to ensure all licenses and certifications are kept current. Findings will be communicated in writing to the facility-wide QA Committee on a quarterly basis for 3 quarters. If no deficiencies are found, reporting will be on a periodic basis. Staff will be reminded the license or certification renewal needs to be completed or they will	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview with Human Resources Manager on 8/11/2011 at 2:45 P.M., she indicated CNA #4 should not have been working on an expired certification and had been suspended pending certification renewal. 3.1-14(s)		be suspended until renewal is completed. When renewed, 2 copies will again be made. 1 copy will be placed in the Licinsing Manual and 1 copy will be placed in the employee file. This will be completed by the Director of Human Resources or Employment Specialist in the absense of the Director. The Licensing Manual is set up by License/Certification i.e., RN, LPN, CNA, Month and Year.	
F0505 SS=D	The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to promptly notify the physician of an abnormal urine culture and sensitivity test and obtain treatment for 1 of 24 residents reviewed for laboratory tests in a sample of 24. (Resident #81) Finding includes: 1. The clinical record for Resident #81 was reviewed on 08/09/11 at 2:00 P.M. A physician's order, dated 08/03/11 indicated the following: "...ua (urinalysis) cath send c and s (culture and sensitivity) if + (positive) dip." Review of a laboratory test result for the "ua" test indicated there were many bacteria, white blood cells, and nitrites in	F0505	1. It is the policy of Byron Health Center that all residents will have prompt notification of diagnostic specimen testing results directed to their physician. This policy action was noted not to occur on 8/6/11 nor on 8/7/11. Staff involved were educated and counseled by the Administrator. No indications of any complications were found with resident #81.2. All nurse managers and shift supervisors reviewed the Byron Health Center procedure for promptly informing the physician of abmormal diagnostic specimen results.3. All potential residents who could have been affected (by having pending diagnostic specimen results) were assessed. Byron Health Center's Clinic nurse's findings were that all abnormal results were directed to residents' physician/agent for response in a	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident's urine. A culture and sensitivity test was performed. The culture and sensitivity report, completed 08/06/11. However, the physician's assistant was not notified until 08/08/11 and an antibiotic to treat the resident's urinary tract infection was ordered. Interview with the Director of Nursing, on 08/10/11 at 2:05 P.M. indicated there was no good reason why the physician was not notified over the weekend of the need for an antibiotic. 3.1-49(f)(2)		prompt time frame. The assessment period was from 8/1/11 and ongoing.4. All nurse managers reviewed Byron Health Center's procedure for notifying the resident's physician of abnormal diagnostic lab results. Procedure adherence shall be audited by the clinic nurse to maintain accountability of practice of physicain notification. All outgoing nurse managers and shift supervisors will now report or email to oncoming managers and shift supervisors of pending results of diagnostic specimens. Clinic nurse/designee will monitor and then report pending diagnostic specimens final reports to outgoing nurse manager/superviors to enable prompt notification of results to physican/agent.Nurse managers will monitor incoming specimen reports mailbox on a daily basis and record findings. These findings will be reported to the facility wide QA committee on a quarterly basis for two quarters. If compliance is in place and no missed specimen reports are noted the Medical Office will continue to report this information on a periodic basis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review the facility failed to correctly document oxygen use and restraint release for 1 of 3 residents reviewed for oxygen documentation (Resident #32) and 1 of 3 residents reviewed for restraint release documentation (Resident #32). Findings include: 1. Resident #32's record was reviewed 8/8/2011 at 10:50 A.M. Resident #32's diagnoses included but were not limited to; mental retardation, depression, and arthritis. A current physician's order dated 8/2011 indicated Resident #32 was have oxygen administered at 4 liters per minute per nasal canula. In an observation on 8/8/2011 at 12:23 P.M. Resident #32 was in her wheel chair	F0514	1a. It is the policy that all Byron Health Center residents will be assessed to reduce the use of restraints and to use the least restrictive means. Our restraint use documentation record was incomplete for one resident. Byron Helth Center procedures require staff (CNA/Nurses) to initial completion of documentation. This resident did not suffer any ill effects from this imcomplete documentation of resident care records.1b. It is the policy that all residents requiring the use of oxygen administration will have the flow rate ordered by the physician to be monitored by the nurse. The documentation was incomplete for one resident. The staff involved was counseled. The resident did not suffer any ill effects from this incomplete documentation of resident care records.2a. All residents using oxygen administration were assessed as being at risk for this deficit practice. When assessed this incorrect documentation of	09/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the dining room. Her oxygen was set on 3 liters per minute. When the oxygen walker was checked, the walker was noted to be empty. The observation continued until 3:20 P.M. The oxygen was never refilled. Resident #32's skin was pink and breathing was full and regular. She exhibited no signs of distress. Oxygen administration was documented on 8/8/2011 on the 7-3 shift as having been delivered at 4 liters per minute. In an observation on 8/10/2011 at 8:02 A.M., it was noted resident #32's oxygen was set on 3 liters per minute. The oxygen walker was full when checked. The observation continued until 11:20 A.M. The oxygen flow had not been changed during the observation. Resident #32's skin was pink and her breathing was full and regular. Resident #32 exhibited no signs of distress. Oxygen administration was documented on the 7-3 shift for 8/10/2011 as having been delivered at 4 liters per minute. In an interview on 8/10/2011 at 1:30 P.M. the Director of Clinical Services indicated oxygen should have been documented as it was given. A current physician's order dated 8/2011 indicated a soft waist restraint to be used when up in chair was to be checked every		monitoring the flow rate using Byron Health Center's procedure for the use of CNA assignment sheets, the TAR, and the CNA checkoff list to monitor correct flow rate was found.2b. All residents using oxygen administration were assessed as being at risk for this deficit practice. Nurse manager assessed for proper flow rate documentation of the TAR for 8/1/11 through 8/12/11. The monitoring/documentation was not complete for the above resident only. The staff involved was counseled.3. A training module was presented to all nursing staff on the procedure for use of CNA worksheets and TARs, and the responsibility to document the use of restraints according to Byron Health Centers procedures. The proper documentation of oxygen administration and monitoring of the correct flow rate each shift was also provided in a training module offered to all nurses. The training is provided 8/23/11 through 9/12/11 by the Education Director.4. Each unit manager/supervisor for each shift will monitor on a daily log the findings of correct documentation of oxygen flow rates, and the completion of restraint records. (See Attachment F514-A) This log will be kept in a binder in the supervisor's office. Each month a summary report will be submitted per the Education Director with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hour and released every 2 hours During a continuous observation on 8/8/2011 between 12:23 P.M. and 3:22 P.M. Resident #32 was up in her wheel chair with a soft waist restraint on in the hall, in the lobby, in the resident lounge, and at bingo without the restraint being checked or released during that time. Her restraint was released and she was toileted at 3:22 P.M. when she asked CNA#1 to take her to the restroom. During a continuous observation on 8/10/2011 between 8:02 A.M. and 11:20 A.M. Resident #32 was up in her wheel chair with a soft waist restraint on in the dining area, went to therapy, to the lobby, then back to her room without the restraint being checked or released during that time. Her restraint was released and she was toileted at 11:20 A.M. when she asked CNA #2 to take her to the bathroom. In an interview on 8/10/2011 at 11:30 A.M. LPN #3 indicated there was no restraint release sheet in the CNA documentation book for the CNAs to document restraint release on. In an interview on 8/10/2011 at 1:30 P.M. the Director of Clinical Services indicated there should have been a restraint release		findings to the QA Committee for 9 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation sheet for the CNAs to document restraint release. 3.1-50(a)(2)			